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Introduction

Peterson Worldwide (a wholly owned subsidiary of Navigant Consulting, Inc. and hereinafter referred to as "Peterson") was retained by the Tennessee Department of Commerce and Insurance on August 24, 1999 to obtain an understanding of the issues, challenges and concerns that exist between the Tennessee Provider community and the various TennCare Managed Care Organizations ("MCOs"). Peterson's findings and general recommendations related to this engagement were included in a draft report dated October 15, 1999 and presented to the TennCare Claims Processing Committee on or about December 1, 1999.

At the request of the TennCare Claims processing panel, Peterson was subsequently retained to develop a listing of specific claims processing policies, procedures and standards related to the general recommendations included in our October 15, 1999 draft report. In conjunction with the development of the standards and recommendations included in this report, Peterson attempted to incorporate information obtained from the following:

- Participating Providers in the TennCare program;
- TennCare participating MCOs;
- Various healthcare associations (i.e., Tennessee Pharmacy Association);
- HIPAA; and
- Industry guidelines.

In reviewing the recommendations and comments included in this report, Peterson suggests that the TennCare Claims Processing Committee adopt those standards that are consistent with the goals of the committee as well as the federal government's Administration Simplification Proposed Regulations. These goals include, among others, the following:

- Improve service to beneficiaries and health care Providers;
- Improve control of TennCare program expenditures;
- Lower administrative costs;
- Increase operational efficiency;
- Increase standardization;
- More effectively combat fraud and abuse; and
- Accommodate managed care and alternative payment methodologies.

Any standard adopted by the committee should be consistent with the objective of reducing the administrative costs of providing and paying for health care services.

I. It is recommended that TennCare consider working with the Providers and MCOs in developing a standardized set of policies and procedures related to the adjudication of TennCare claims.

A. Rationalization

1. There is a lack of consistency and uniformity with documentation and claims processing requirements within a single MCO and among the various MCOs, therefore requiring Providers to establish different claims processing procedures for each MCO.

2. Administrative policies vary across MCOs. For example, with regard to checking the status of claims that have been submitted for payment, one MCO allows a Provider to inquire about five claims, another may allow three, while another allows unlimited status inquiries.

3. As of the date Peterson conducted interviews, a majority of the MCOs had failed to distribute current MCO Billing Policy and Procedure Manuals to their contracted Providers.

4. Various Providers are unaware of specific MCO policies and procedures. This lack of communication and information leads to additional claim denials that could be prevented with improved communication of policies and procedures.

5. The Health Insurance Portability and Accountability Act of 1996 (HIPAA) proposed standards for administrative simplification create guidelines for the electronic transmission of healthcare data.

B. Industry/Suggested Standards

1. Create uniform policies and procedures across all TennCare MCOs regarding documentation and claims processing requirements.

    a. Develop policies and procedures related to the submission of claims (i.e., electronic and paper submissions). These policies should encompass all aspects of elements required for the appropriate adjudication of claims. Policies should include, but are not limited to, the following:

        (1) Timely Filing for Submission of Claims
        (2) Julian Date Assignment
        (3) Claims Processing Timeliness
        (4) Eligibility Criteria
        (5) Pre-Authorization/Certification
        (6) Claim Form Submission
        (7) Complaints and Grievances
        (8) Provider Credentialing

(9) Physician Referrals
(10) Claims Payment Information

(a) Paid Claims
(b) Denied Claims
(c) Suspended Claims

(11) Coordination of Benefits
(12) EMTALA and COBRA Requirements
(13) HCFA Common Procedure Coding System
(14) Customer Service/Inquiries
(15) Other

b. Develop policies and procedures related to claim status inquiries.

2. Uniform policy and procedure manuals should be distributed to all Providers participating in the TennCare program.

3. Uniform policy and procedure manuals should be reviewed on an annual basis and redistributed to reflect updates, changes or modifications. Current and complete information should improve communication between Providers and MCOs regarding the adjudication of TennCare claims.

C. Benefits

1. Aggressive implementation of the HIPAA standards provide opportunity to become a market leader and improve competitive advantage.

2. Reduction in administrative costs;

a. Labor savings in enrollment verification, claims processing, medical records and other areas;

b. Reduce repeated capture of patient demographics by providing electronic access to patient information;

c. Improved quality of claims data and associated reduction in the cost of processing claims;

3. Reduced accounts receivables;

4. Reduced opportunities for medical errors that often result from poor information;

5. Reduction in fraudulent claims;

6. Providers may opt to perform clearinghouse functions for their own transactions or for others. This will greatly improve physician networks by electronic transmissions of patient information.

D. Steps to Implement

1. Obtain and review all current policy and procedure manuals from MCOs related to the adjudication of TennCare claims.

2. Obtain and review pertinent information from private and public sector payers.

3. Obtain and review relevant HIPAA proposed standards for administrative simplification.

4. Obtain and review standards proposed by formalized standard setting organizations (i.e., NCQA, JCAHO, etc.).

5. Identify consistencies and inconsistencies among the various policies and procedures discussed in the resources mentioned above.

6. Establish feasible policies and procedures consistent with HIPAA's proposed standards for administrative simplification.

7. Create a standard set of policies and procedures to be consistent amongst all MCOs.

8. Distribute this standardized manual to all Providers participating in the TennCare program.

II. It is recommended that TennCare work with the Providers and MCOs in assessing the feasibility of creating standardized Remittance Advices across MCOs.

A. Rationalization

1. Each MCO utilizes a different format in their creation of Remittance Advices (RAs) they distribute to Providers.

2. Beneficiary claim information included on the RAs varies amongst MCOs.

3. Providers often find information included on the RAs confusing and insufficient.

4. Multiple Providers expressed concern with the inability to discern reasons for claim denials from the limited information included on RAs.

5. Currently, Providers must interpret various RA coding schemes used by each MCO.

6. RAs are mailed by each MCO to providers in different intervals.

B. Industry/Suggested Standards

1. Create a uniform mechanism of payment and notification across TennCare MCOs.

2. Information contained on uniform RAs should contain (but is not limited to) the following:

    a. Patient Name
    b. Patient Account Number
    c. Enrollee ID Number
    d. Claim Number
    e. Date of Service
    f. DRG#
    g. Revenue Code
    h. Procedure
    i. Count Days/Qty
    j. Total Charges
    k. Covered Charges
    l. Provider Contract Adjustment
    m. Patient Non-Covered Charges
    n. Patient Deductible, Co-pay and Coinsurance
    o. Other Insurance/Medicare Paid
    p. Withhold Amount
    q. Net Payment
    r. Amount Due from Patient

3. The Department of Health and Human Services specifies the ASC X12N 835 Health Care Claim Payment/Advice (004010X091) as the standard for payment and RA transactions.

    a. The ASC X12N 835 may be used in conjunction with payment systems relying either on electronic funds transfer or the creation of paper checks.

    b. It may be sent through the banking system or it may be split with the electronic funds transfer portion directed to a bank, with the data portion sent either directly or through a health care clearinghouse to the individual for whom the funds are intended.

    c. If paper checks are used, the entire transaction is sent either directly or through a health care clearinghouse to the individual for whom the funds are intended.

    d. In all cases, however, the health care Provider may use the electronic data within their own system, gaining efficiency by means of automatic posting of patient accounts.

    e. Uniformity is just as important as it is for health care claims, since there would be little gain in efficiency for the health care Provider who must adapt to multiple formats and multiple data contents for RAs.

    f. This transaction is suitable for use only in batch mode.

4. Create uniform intervals for distribution of RAs (i.e., RAs will be mailed twice monthly).

C. Benefits

1. A uniform system for RAs notifications will reduce the complexity of the current system.

2. Standard RAs will require the interpretation of one (as opposed to multiple) format.

3. Automation around a standard model for Ras can greatly reduce the labor required for these processes. Providers and their administrative staff are not required to learn and interpret various RA formats.

4. Automation allows health care Providers to post claim decisions and payments to accounts without manual intervention, eliminating the need for re-keying data.
5. Payments can be automatically reconciled to patient accounts; and resources are freed to address patient care rather than paper and electronic administrative work.

6. ASC X12N 835 - Health Care Claim Payment/Advice was the best candidate, selected for adoption under HIPAA. A wide range of the health care community participated in its initial design, and the ASC X12N is ANSI accredited.

a. Other models did not improve the efficiency and effectiveness of the health care system often because they lacked standard implementation.

b. Some were developed primarily for Medicare and, therefore, did not meet all of the needs of the user community.

c. Systems with fixed-length structure do not incorporate flexibility to adapt easily to change.

D. Steps to Implement

1. Obtain and review all policies and procedures related to the mailing of RAs from MCOs.

2. Assess needs of Providers relating to the time frame of RAs being mailed by MCOs.

3. Implement a uniform automated system for use by all TennCare MCOs as proposed by HIPAA. The implementation guide for the ASC X12N 835 (004010X091) is available at no cost from the Washington Publishing Company website at the following Internet address: http://www.wpc-edi.com/hipaa/.

4. Develop a standard set of policies and procedures relating to the transmission and distribution of RAs from MCOs.

III. It is recommended that TennCare work with Providers and MCOs in assessing the feasibility of establishing a mechanism by which the Providers are able to access MCO data to determine the status of claims submitted for adjudication.

A. Rationalization

1. Multiple Providers expressed that MCO claim representatives were impatient when they called to inquire about claim status.

2. Providers expressed concern with the information they received from MCOs regarding claim status questions. Specifically, it was stated that conflicting information was received depending on who answered their inquiries.

3. As previously stated, there is a lack of uniformity between administrative policies regarding checking the status of claim payments.

4. Generally, information regarding the status of a particular claim is communicated telephonically when the Provider calls the MCOs.

5. The ability for Providers to access claim information in a read-only format is currently being utilized by some MCOs. This method, once employed, has been well received by both MCOs and Providers.

B. Industry/Suggested Standards

1. Although there is no industry standard for this, in order to expedite responses from MCOs, Providers should be prepared with the following information when inquiring about claim status:

    a. Member Name
    b. Member Identification Number
    c. Provider Name
    d. Provider Number
    e. Date of Service
    f. Amount Billed on the Claim

2. Any mechanism employed must be consistent and uniform with HIPPA and other private and public sector health data standards in providing for privacy and confidentiality.

3. Confidentiality of certain health care Provider data must be maintained and tightly controlled.

C. Benefits

1. Initial investment in developing a Provider specific "claims status" report for online viewing will result in long term reduction in administrative costs.

2. Initial investment in developing a system that allows Providers to access claim status report will result in long term reduction in administrative costs.

3. Initial user-training costs.

4. Reduction in administrative expenses resulting from fewer Provider inquiries.

5. Potential reduction in administrative costs resulting from fewer duplicate claims.

6. Improved Provider satisfaction resulting from direct access to claim information.

D. Steps to Implement

1. Obtain information on existing MCOs that have implemented a mechanism for Providers to access claim data.

2. Assess MCO and Provider hardware capabilities.

3. Assess MCO and Provider software capabilities.

4. Identify potential communication and/or interfacing packages.

5. Identify needs for additional computer cabling and wiring.

6. Develop security standards related to privacy and confidentiality to ensure compliance with the standards outlined in the HIPAA.

7. Identify data fields that will be made available to Providers for checking on claim status.

8. Assign passwords for user "read-only" access.

9. Develop an implementation plan and timeline.

10. Perform system implementation steps identified in #9 above.

11. Provide user training.

IV. It is recommended that TennCare work with the Providers and MCOs in developing clear, concise, measurable and objective standards related to the submittal and adjudication of TennCare claims (i.e., accuracy standards, processing standards, etc.)

A. Rationalization

1. There are variations in MCOs interpretation of the definition of a "clean claim."

2. There are variations in the timeliness of controlling submitted claims by MCOs.

3. There are inconsistencies among MCOs with the enforcement of timely filing requirements.

4. Third Party Liability (TPL) recoupment requests are coming to Providers late and subsequent submissions to MCOs are being denied for timely filing.

B. Industry/Suggested Standards

1. Timely Filing – based on date claim submitted and date of service. The MCO must allow the Provider at least 120 days to submit a claim and effective 7/1/96, no more than 180 days to file a claim from the date of service.

2. Assignment of Document Control Number – claims received by the MCOs mailroom will be assigned a document Control Number or equivalent within twenty-four (24) hours of receipt of such claim.

3. The MCOs shall ensure that ninety percent (90%) of claims for payment for service delivered to a TennCare enrollee (for which no further written information or substantiation is required in order to make payment) are paid within thirty (30) days of the receipt of such claims. The MCOs shall process, and if appropriate pay, within sixty (60) days ninety nine and one half percent (99.5%) of all Provider claims for services delivered to an enrollee in the TennCare Program. The term "process" means the MCOs must send the Providers a written RA or other appropriate written notice evidencing either that the claim has been paid or informing the Provider that a claim has been either partially or totally "denied" and specify all known reasons for denial. If a claim is partially or totally denied on the basis the Provider did not submit any required information or documentation with the claim, then the RAs or other appropriate written notice must specifically identify all such information and documentation. The term "pay" means that the MCOs shall either send the Provider cash or cash equivalent in full satisfaction of the allowed portion of the claim, or give the Provider a credit against any outstanding balance owed by that Provider to the MCOs.

4. MCOs will process all claims received with ninety-eight percent (98%) accuracy.

5. Appeals/grievances should be submitted by Providers/enrollees within forty-five (45) days of denial.

6. Ninety-five percent (95%) of appeals/grievances processed within sixty (60) days from date of request.

C. Benefits

1. Consistent application of claims processing timeliness and accuracy will minimize confusion among Providers and MCOs.

2. Consistent application of claims processing timeliness and accuracy may result in administrative savings resulting from reduced submission of duplicate claims.

3. Potential reduction in claim inquiries.

4. Consistent application of claims processing timeliness and accuracy standards would potentially result in expedited payment to Providers (i.e., improved case flow).

5. Consistent application of claims processing timeliness and accuracy standards would result in improved customer service.

6. Consistent application of claims processing timeliness and accuracy standards would minimize erroneous payments to Providers.

D. Steps to Implement

1. Communicate claims processing standards, as adopted, to Providers and MCOs.

2. Develop detailed audit protocol related to claims processing and timeliness standards.

3. Require quarterly reporting, at a minimum, related to claims processing timeliness and accuracy.

4. Require routine reporting to TennCare related to claims backlog, and pending claims (i.e., claims inventory).

5. Develop corrective action plans for inefficiencies reported, if applicable.

V. It is recommended that TennCare work with the Providers and MCOs in developing a standardized set of denial codes.

A. Rationalization

1. There is a lack of uniform denial codes within the various MCOs.

2. In order to submit claims properly, Providers need to understand the definition and reason for denials related to TennCare claims.

3. Providers may have stopped servicing new TennCare patients because they believe that MCOs are denying claims inconsistently and/or inaccurately.

4. The lack of uniform denial codes among MCOs requires Providers to interpret and process appeals differently for each MCO they work with.

B. Industry/Suggested Standards

1. Although no standard format exists, a uniform set of denial codes for all MCOs should be created. This list should be accompanied by detailed descriptions of each denial code.

2. Denial codes should be created consistent with other public and/or private practices.

3. Reasons for denial should be communicated to Providers without exception so as to reduce the likelihood of multiple claims submissions with multiple denials.

C. Benefits

1. A standardized set of codes will expedite appeals thereby preventing a backlog of claims.

2. A standardized list of denial codes will provide uniformity for the benefit of Providers.

3. Standardized denial codes will ultimately aid the claims adjudication process by making the Providers more acutely aware of what leads to their denials so that they can address those issues proactively.

4. Uniform denial codes among the MCOs will eliminate ambiguity that has led some Providers to question the veracity of the MCOs claims adjudication process.

5. Appeals submitted in response to denials should be more concise using standardized denial codes.

6. Standardized denial codes may result in reduced administrative costs.

D. Steps to Implement

1. Obtain and review all denial codes from various MCOs.

2. Assess the needs of the Providers as they relate to denial codes.

3. Develop a standardized set of denial codes that will give Providers necessary information.

    a. All information necessary to correct claims that are submitted erroneously.
    b. All information necessary to appeal in a timely manner.

4. Provide all reasons for the claim denial to the Provider simultaneously.

VI. It is recommended that TennCare work with the Providers and MCOs in establishing a standardized set of procedure codes and modifiers to be used in conjunction with the adjudication of TennCare claims.

A. Rationalization

1. MCOs IT Claims Systems do not recognize all current procedure codes. Therefore, Providers must send additional information related to the current procedure code to the MCOs to have the claim processed. Additionally, some MCOs IT Claims Systems do not recognize modifiers to procedure codes, leading to inappropriate denials.

2. Additional procedure codes required by MCOs to process claims require manual entry.

3. Sometimes, Providers must use different coding guidelines when dealing with different health plans. This leads to less effective claims submission and higher denial rates.

4. NHIA is working with HCFA to establish standardized coding in accordance with the HIPAA. ICD-10 has not been released yet, but it will be the latest code set as outlined by HIPAA. This code set has been adopted internationally.

B. Industry/Suggested Standards

1. Mandate a standard procedure code and modifier set to be used and recognized by the MCOs, health care clearinghouses, and Providers.

2. Recognize the anticipated release of ICD-10 and consider using it as the basis for a uniform code set within TennCare MCOs.

3. Address the disparity between what is covered by TennCare MCOs and what services are required of Providers by EMTALA and COBRA.

4. Develop and maintain capability to recognize and process all standard codes (i.e., HCPCS and CPT).

C. Benefits

1. A uniform procedure code set will decrease the number of claims that are currently denied due to the different code sets currently recognized within TennCare MCOs. This will decrease the volume of appeals that are subsequently submitted to the MCOs.

2. Conformity with ICD-10 will ensure that TennCare MCOs are well positioned to be compliant with HIPAA.

3. There will be a one-time cost to implement universal coding as well as the possibility of temporary disruptions in processing claims, but administrative savings and increased data integrity should compensate for these.

D. Steps to Implement

1. Collect and review current procedure code and modifier lists used by all TennCare MCOs.

2. Determine which discrepancies exist between code sets.

3. Create a uniform set of procedure codes for use by the MCOs, health care clearinghouses and Providers. This list should be HIPAA compliant and should be flexible enough to accommodate future HIPAA amendments as they pertain to procedure codes.

4. Mandate implementation of standard code sets (i.e., ICD9/10, CPT and HCPCS).

VII. It is recommended that TennCare work with the Providers and MCOs in assessing the feasibility of establishing a standardized Provider number classification system across all MCOs.

A. Rationalization

1. Certain MCOs are requiring multiple Provider numbers for each individual Provider. This leads to confusion about which Provider number should be used.

2. MCOs assign Provider numbers independently resulting in the Provider having different numbers for each plan. This can significantly complicate the claims submission process.

3. Nonstandard enumeration contributes to the unintentional issuance of the same identification number to different Providers thus complicating the claims submission process.

4. HIPAA will adopt a standardized unique health identifier for each individual, employer, health plan, and health care Provider for use in the health care systems.

5. The lack of a single and unique identifier for each Provider within each health plan and across health plans makes exchanging data both difficult and expensive.

6. As TennCare becomes more dependent on data automation and proceeds within its planning for future health care needs, the requirement for a universal, standard health care identifier becomes increasingly evident.

B. Industry/Suggested Standards

1. Institute a uniform system for assigning Provider numbers identifiable by all TennCare MCOs.

    a. HCFA will be instituting the National Provider Identifier (NPI) to serve as a universally accepted national identification and enumeration system for health care service Providers. The target effective date is June 1, 2000 and implementation date is December 31, 2002.[1]

    b. As of the date of this report, the NPI is an eight-position alphanumeric identifier. The eighth position is an International Standards Organization-approved check digit, which will allow a calculation to detect keying or transmission errors. However, HCFA has received recommendations that the identifier be a ten-digit numeric.[2]

[1] Effective date is the day HCFA sets the standard. The implementation date is the day all Providers should be assigned a National Identifier.
[2] Pat Peyton at HCFA recommends preparing for a ten-digit identifier.

c. The NPI includes a one -position numeric check digit. Utilization of a check digit serves two main purposes.

(1) The check digit is utilized to assist the detection of transposition and transcription errors involving the NPI before the transmission of transactions. These errors may occur when the NPI is read over the telephone, handwritten on forms, or keyed into a computer.

(2) The check digit can assist in the process of determining if the eight-digit identifier provided is a valid NPI. Only 10 percent of all possible eight-character combinations produce values, which are potential NPIs. The check digit can eliminate the other 90 percent of combinations.

d. NPI was selected by HCFA over other commonly used identification numbers because:

(1) The National Supplier Clearinghouse number or the Unique Physician Identification Number applies to only small segments of the community.

(2) The Employer Identification Number, the Social Security Number, and the Drug Enforcement Administration number, were established for other government programs and are not appropriate for identification of health care service Providers.

(3) The National Supplier Clearinghouse number or the Unique Physician Identification Number apply only to small segments of the Provider community.

(4) The Medicare Provider number assigned to certified, mainly institutional, Providers, have a format that will not accommodate a sufficient number of future health service Providers.

(5) The Health Industry Number, developed by the Health Industry Business Communications Council, is proprietary.

(6) Standard Provider identifiers must be easily accessible (i.e., health plans must be able to obtain identifiers and other key data easily in order to use the identifier in electronic transactions).

(7) The identifier must be comprehensive and accommodate all health care Provider types.

(8) The identifier should be consistent with HIPAA and other public and private sector health data standards.

(9) The identifier must provide for confidentiality and privacy.

(10) The identifier must be flexible to change.

(11) The identifier should be issued by one or more departments / organizations responsible for the distribution and administration of the numbers.

(12) The Provider file data elements should include (but is not limited to) the following:

- National Provider Identifier (NPI).
- Provider's current name
- Provider's other name
- Provider's legal business name
- Provider's name suffix
- Provider's credential designation
- Provider's Social Security Number (SSN)
- Provider's Employer Identification Number (EIN)
- Provider's birth date
- Provider's birth state code
- Provider's birth county code
- Provider's birth county name
- Provider's birth country name
- Provider's sex
- Provider's race
- Provider's date of death
- Provider's mailing address
- Provider's mailing address telephone number
- Provider's mailing address fax number
- Provider's mailing address e-mail address
- Resident/Intern code
- Provider enumerate date
- Provider update date
- Establishing enumerator/agent number
- Provider practice location identifier (location code)
- Provider practice location name
- Provider practice location address
- Provider's practice location telephone number
- Provider's practice location fax number
- Provider's practice location e-mail address
- Provider classification
- Provider certification code
- Provider certification (certificate) number
- Provider license number
- Provide license State
- School code
- School name
- School city, state, country
- School graduation year

- Other Provider number type
- Other Provider number
- Group member name
- Group member name suffix
- Organization type control code

C. Benefits

1. A unique Provider identification number will reduce the complexity of the current system.

2. A unique Provider identification number will enhance fraud and abuse efforts.

3. A unique Provider identification number may reduce administrative costs.

4. A unique Provider identification number will simplify the claims submittal process.

5. A unique Provider identification number will improve the quality and accuracy of data collection efforts related to costs and utilization of health care services.

D. Steps to Implement

1. Prepare for the transition to the NPI system during 2000-2001.

   a. Develop ten-digit alphanumeric identifier used by all MCOs and their clearinghouses. This will allow for the maximum digits proposed by HCFA.

   b. Determine whether to enumerate NPIs at the state level.

   c. Determine whether the NPIs should capture practice addresses.

      (1) Pros – Practice addresses could aid in non-electronic matching of Providers and in conversion of existing Provider number systems to NPIs. They could be useful for research specific to practice location, for example, involving fraud or epidemiology.

      (2) Cons - Practice addresses would be of limited use in the electronic identification of Providers. The large number of practice locations of some group Providers, the frequent relocation of Provider offices, and the temporary situations under which a Provider may practice at a particular location would make maintenance of practice addresses burdensome and expensive.

   d. Determine whether the NPS should assign a location code to each practice address in a Provider's record.

(1) Pros – The location code could be used to designate a specific practice address for the Provider, eliminating the need to perform an address match each time the address is retrieved. The location code might be usable as a designation for service location in electronic health transactions

(2) Cons – Location codes should not be created and assigned nationally unless required to support standard electronic health transactions; this requirement has not been demonstrated. The format of the location code would allow for a lifetime maximum of 900 location codes per Provider; this number may not be adequate for groups with many locations. The location code would not uniquely identify an address; different Providers practicing at the same address would have different location codes for that address, causing confusion for business offices that maintain data for large numbers of Providers.

e. Determine whether group and organization Providers share the same organization data structure in the NPS. If so, the NPS would have two data structures, one for individuals and one for organizations. Enumerated individuals could be listed as members of an organization. Their NPIs would be linked to the NPI of the organization. Each separate physical location or subpart of an organization that needed to be identified would receive its own NPI. The NPS would not link the NPI of an organization to the NPI of any other organization, although all organizations with the same Employer Identification Number (EIN) or same name would be retrievable via a query on that EIN or name.

(1) Pros - This data structure would provide flexibility for enumeration of integrated Provider organizations. It would eliminate an artificial distinction between groups and organizations. It would eliminate the possibility that the same entity would be enumerated as both a group and an organization. It would eliminate any need for location codes for organizations. It would allow linkage of organization members to a separately enumerated physical location or subpart of an organization. It would allow enumeration at the lowest level that needs to be identified, offering flexibility for enumerators, health plans or other users of NPS data to link organization NPIs as they require in their own systems.

(2) Cons - More data entry and maintenance could be required, if the same individuals need to be entered as members for each separately enumerated physical location or subpart of an organization. A single business entity could have multiple NPIs, corresponding to its physical locations or subparts.

VIII. It is recommended that each MCO conduct annual training seminars and improve communication pathways for Providers related to the proper submission of TennCare claims.

A. Rationalization

1. The Provider community is often uncertain as to what TennCare MCOs expect or require for the proper submission of claims.

2. Providers have received conflicting information from various individuals within the same MCO as to how they should submit claims (e.g., attachment requirements, timeframes, etc.).

3. TennCare MCO representatives and Providers do not currently meet on a regular basis to discuss challenges and obtain clarification on claim submission procedures.

B. Industry/Suggested Standards

1. Create annual claims processing training seminars sponsored by all TennCare MCOs. These seminars will be designed to provide further training to Provider Billing Representatives as it applies to the TennCare claims submittal process.

   a. The recommended training should be similar to HCFA's proposal to establish a national Provider training and education program to study various Medicare benefits, coverage and billing policies.

   b. HCFA Provider education proposals also include Internet-based training and satellite technology to make education more readily available to Providers throughout the nation, saving on travel, challenging schedules, and office hours.

2. Improve Provider relations at MCOs and communication between Providers and MCOs. The following could serve as examples:

   a. Blue Cross Blue Shield of North Carolina maintains a panel of Provider Relation's Representatives who have divided the state by county with one person assigned to each region. These individuals are on call for advice and counsel to Providers (accessible through a toll-free number) and frequently travel to counties to work with county or regional Provider associations.

   b. Blue Cross Blue Shield of North Carolina initiated a Provider advisory group comprised of pediatricians, family practice physicians, dentists, ophthalmologists, audiologists, pharmacists and public health clinics. The advisory group is looking at ways to maximize Provider education and involvement in the program.

C. Benefits

1. Improved communication may help to reduce Provider tension resulting from claim denials for incorrect submission.

2. Training will help to streamline claims processing across the TennCare program.

3. Training may reduce MCO administrative expense by decreasing the volume of individual questions and concerns that are received over the phone and through the mail.

4. Increased training may result in fewer duplicate/resubmitted claims.

5. Training and improved communication could reduce the prevalence of fraud and abuse as rules are streamlined and consensus on rules develops.

6. Online training provides immediate access to claims processing information for Providers and administrative staff. This should also reduce administrative costs.

D. Steps to Implement

1. Determine which specific claims submission challenges are most prevalent from the perspective of the MCOs and the Providers.

2. Although there are no current regulations regarding the implementation of training programs, we recommend a TennCare panel oversee the MCOs development and execution of substantive training programs that incorporate all aspects of claim submission including, (but not limited to) information about coding, timeliness, medical necessity, third-party liability, prior authorization and member eligibility. These seminars should be conducted throughout the state and should be done uniformly so that a Provider is only required to attend one.

3. Develop an online training program that will allow a Provider the opportunity to search for policies and procedures regarding the submission of claims. This program should also incorporate a mechanism through which questions could be answered online or via e-mail.

IX. It is recommended that Providers and MCOs conduct, at a minimum, bi-monthly training related to the submission and adjudication of TennCare claims. Claims processors, billing clerks, patient account managers and customer services personnel should be included in the training process.

A. Rationalization

1. The pre-certification process that is required by some MCOs is inefficient and cumbersome. This leads to services being rendered by Providers prior to authorization or pre-certification being obtained. The MCOs may ultimately deny these claims.

2. As of the date of the interviews, a majority of the MCOs have failed to supply to their contracted Providers current MCO Billing Policy and Procedure Manuals.

3. MCO personnel lack the requisite knowledge of the MCO's policies and procedures.

4. The Provider community is unfamiliar with MCO policies and procedures.

5. MCO service representatives are impatient with Providers who call to check on claims status.

6. MCOs lack organization and consistency when handling customer service issues.

B. Industry/Suggested Standards

1. Training will be required to adopt electronic standards to facilitate all claims processing and adjudication processes, including the precertification process. For example, the ASC X12N 278 code sets may be used by Providers to request and receive approval (pre-certification) from an MCO through an electronic transaction prior to providing a health care service.

2. Providers and MCOs should conduct bi-monthly training for claims processors, billing clerks, patient account managers and customer service personnel to improve communication and the quality of service provided to each other and to recipients (the National Uniform Billing Committee (NUBC) recommends monthly meetings).

   a. Training administrative staff will streamline the pre-certification process so that fewer patients receive services without pre-certification. Provider staff should be responsible for ensuring pre-certifications and authorizations are obtained.

   b. Bi-monthly training will ensure that each Provider obtains a copy of the MCOs policy and procedure manual. Providers' administrative staff will

have increased opportunity to become familiar with the policies and procedures necessary to facilitate a positive and working business relationship with payers.

c. Training may improve MCO service representatives' attitudes towards Providers resulting in improved customer service. It may also result in more consistency in handling customer issues.

C. Benefits

1. Frequent training will allow administrative staff, Providers and others involved with claims processing to keep abreast of technological advancements and implementation.

2. Frequent training and improved communication creates a forum for the discussion of new ideas to improve processes.

3. Additional training will reduce Provider and payer errors resulting in administrative cost savings.

4. Additional training will result in improved communications between Providers and MCOs.

D. Steps to Implement

1. Obtain and review all policies and procedures related to claims submission and adjudication.

2. Develop a minimum standard set of policies and procedures and/or guidelines relating to the pre-certification of a patient.

3. Develop training course materials.

4. Develop training schedule.

5. Follow the schedule consistently to maximize attendance.

X. It is recommended that the MCOs establish a formal mechanism to communicate system changes and modifications to the Providers in a timely manner.

A. Rationalization

1. MCOs are requiring additional Procedure Codes to process claims that need to be manually entered in Provider IT Billing Systems. These changes are not always communicated to the Providers.

2. MCOs change claims processing requirements without informing Providers or without giving Providers sufficient lead-time to react to the change.

3. Communication between MCOs and Providers has historically been inefficient and ineffective.

B. Industry/Suggested Standards

1. Establish EDI code standards in accordance with HIPAA.

2. Require all MCOs to have the capability to receive and process all standard codes (and modifiers, in the cases of HCPCs and CPT) irrespective of local policies.

3. Establish a fraud mechanism committee to communicate system changes to Providers prior to implementation (i.e., TennCare claims processing committee).

4. Establish a formal request for system change to allow the testing, implementation, and dissemination to all Providers/MCOs.

    a. Establish an e-mail communication system to communicate with Providers and MCOs.

    b. Require written correspondence to Providers.

C. Benefits

1. Initial investment to obtain e-mail addresses for all Providers resulting in the benefit of improved communication between Providers and MCOs.

2. Initial cost to train administrative staff on policies and procedures for communicating system changes to Providers resulting in improved communication between Providers and MCOs.

3. Administrative savings resulting from fewer Provider inquiries.

4. Administrative savings resulting from fewer resubmitted claims (reduced backlog).

5. Provider's ability to prepare for system changes reduces claim resubmissions.

D. Steps to Implement

1. Modify and/or develop an electronic claim filling system that will notify Providers of system changes at least one month prior to implementation and "lock out" improper entry after that period.

2. Assess the current system to insure MCOs have the ability to process standard code sets to predict system changes that may occur in the future.

3. Obtain and evaluate policies and procedures for communicating system changes to Providers.

4. Assess Provider's policies and procedures for receiving and integrating system changes.

5. Establish a help line or other communication mechanism related to challenges encountered in the process of incorporating system changes.

6. Develop an e-mail system to communicate requests for system changes and on-going dialogue.

XI. It is recommended that the Providers and MCOs establish a mechanism to identify and correct challenges that each is experiencing with regard to the submission and adjudication of TennCare claims (i.e., standing committee). It is Peterson's understanding that such a committee is in the process of being formed.

A. Rationalization

1. MCO personnel lack the requisite knowledge of the MCO's policies and procedures.

2. Providers have voiced dissatisfaction with many issues related to claims processing. Direct lines of communication between Providers and MCOs to resolve issues currently do not exist.

3. Providers have threatened to stop seeing TennCare patients due to claims processing problems that may or may not have been communicated directly to the MCO.

B. Industry/Suggested Standards

1. In accordance with Amendment No. 1 to Senate Bill 145, "The Commissioner shall appoint a panel of five (5) persons known as the TennCare Claims Processing Panel."

2. "The Panel shall also conduct a study, with the assistance of staff from the Department of Commerce and Insurance and the Department of Health, to assess whether the State shall require Uniform Claims Processing Requirements….."

C. Benefits

1. Improve communication between Providers and MCOs;

2. Could prevent issues from exacerbating to the point at which Providers refuse to treat TennCare patients;

3. Potential administrative cost savings;

4. Improved Provider/customer satisfaction;

5. More efficient claims submittal processes;

6. Improved knowledge of Provider/MCO requirements.

D. Steps to Implement

1. Select representatives from the Provider community and MCOs to stand on committee.

2. Determine frequency of meetings and set schedule.

3. Set agenda based on observed Provider complaints.

XII. It is recommended that TennCare work with the Providers and MCOs in reviewing the current TennCare eligibility files to identify methods to improve the accuracy and timelines of membership data reported to the MCOs.

A. Rationalization

1. TPL recoupment requests are coming to Providers late, such that Providers exceed the timeliness requirement of the appropriate payer, and the Providers are incurring the losses.

2. The process required of Providers to verify beneficiary eligibility and to discern if any TPL exists is costly.

3. Providers must secure eligibility determinations through telephone calls, mail, proprietary point of sale terminals, or using proprietary electronic formats.

4. MCOs may require that the Providers' requests are in a preferred format, which often does not match the format required by any other health plan. Providers must then maintain redundant software, hardware, and human resources to obtain eligibility information. This process is inefficient, often burdensome, and takes valuable time that could otherwise be devoted to patient care.

5. Providers are experiencing difficulties with eligibility verification systems, as the systems are often not current as of the date of service and therefore denials are occurring for lack of eligibility even though the Provider has a copy of eligibility verification on file.

6. TPL information is often inaccurate.

7. It has been suggested that beneficiary eligibility be recorded by the State on the date the eligibility form is received and not as of the date stamped on the eligibility form.

8. HIPAA proposes standardized eligibility data.

B. Industry/Suggested Standards

1. The Department of Health and Human Services has recommended the ANSI ASC X12N 270 – Health Care Eligibility Benefit Inquiry and the companion ASC X12N 271 – Health Care Eligibility Benefit Response as the HIPAA standard for a health plan transaction.

2. This format can be used by an insurance company, MCOs, a preferred Provider organization, health care purchasers, professional review organizations, third-party administrators, vendors (billing services), service bureaus (value-added networks), and government agencies (Medicare, Medicaid and CHAMPUS).

C. Benefit

1. The value of eligibility information is enhanced if it can be acquired quickly.

2. The proposed standard has relatively low additional development and implementation costs and is consistent with other standards proposed by the Department of Health and Human Services.

3. Response times measured in seconds.

4. Accurate eligibility information resulting in fewer claim denials.

D. Steps to Implement

1. Obtain and examine TennCare's policies and procedures for determining eligibility.

2. Obtain and examine TennCare's definition of timeliness for membership data.

3. Assess the time needs of Providers and MCOs for eligibility requirements.

4. Study a sample population of inaccuracies to determine where and why most are occurring.

5. Develop an electronic eligibility system using HIPAA's proposed format (ANSI ASC X12N 270 and 271) and the information obtained from the assessment of inaccuracies and time needs.

XIII. It is recommended that TennCare work with the Providers and MCOs to formalize the billing/claims dispute resolution process (i.e., independent review organizations). It is Peterson's understanding that such a process is being established.

See Senate Bill No. 1451, Section 1, Paragraph 4, which states:

"The commissioner shall appoint a panel of five (5) persons, known as the TennCare Claims Processing Panel. The Panel shall consist of two (2) Provider representatives, one (1) representative from each of the two (2) MCOs with the largest number of TennCare enrollees as of June 1, 1999, and the Deputy Commissioner of the TennCare Division in the Department of Commerce and Insurance. If either of the largest MCOs declines to serve, the commissioner shall select another TennCare MCO to serve. All decisions of the Panel shall be made by a majority vote of the members of the Panel. The Panel shall select and identify an appropriate number of independent reviewers to be retained by each MCO under subdivision (3) by no later than August 1, 1999. The panel shall negotiate the rate of compensation for each reviewer, and the rate of compensation shall be the same for each reviewer. Each MCO engaged in a TennCare line of business, as a condition of participating as a contractor in the State's TennCare program, shall contract with each reviewer and agree to pay the rate of compensation negotiated by the Panel. The Panel shall also conduct a study, with the assistance of staff from the department of Commerce and Insurance and the Department of Health, to assess whether the state should require uniform claims processing requirements for the MCOs participating in the State's TennCare program. This study shall be completed and provided to the commissioner and the director of the TennCare Bureau by no later than March 31, 2000. The expenses of this Panel shall not be compensated by the State."

XIV. Develop standards that promote data interchange for the home infusion and ambulatory care pharmacy sectors of the health care industry.

A. Rationalization

1. The standardized universal claim (1977), standardized format for tape-to-tape transfers (1978) and the POS Telecommunication Standard (1988) developed by the National Council for Prescription Drug Programs ("NCPDP") facilitated prompt claims adjudication for prescriptions dispensed in commuity based pharmacies.

2. Today, virtually all prescription drug claims dispensed in community based pharmacies are electronically adjudicated, in interactive real-time. Processing time within a PBM for a drug claim submitted from these pharmacies is measured in seconds, not days or weeks, as is the case in other areas of healthcare.

3. The Tennessee Pharmacy Association and the National Home Infusion Association generally agree with the need to standardize the claims processing procedures for pharmacy services and prescriptions delivered by pharmacies providing home infusion services presented to the TennCare Claims Processing Committee on or about December 1, 1999.

4. The Health Insurance Portability and Accountability Act is recommending the continued implementation and utilization of NCPDP standards related to data interchange for the community based pharmacy services sector of the health care industry.

5. Currently, the home infusion sector of the health care industry has little standardization of claims processing procedures. The variations lead to cumbersome administrative processes.

B. Industry/Suggested Standards

1. The pharmacy community supports the development of a universal unique identifier numbering system for prescribers.

2. Mandate use of all NCPDP Standards including:

   a. Billing Unit Standard - Standardizes billing units in the pharmaceutical industry to relieve the number of processors, fiscal intermediaries, plan administrators, and medical programs (i.e., the principal rule of the standard is that there are only three billing units necessary to describe any and all products).

   b. Diskette Standard Format - This standard was intended for processing prescription drug claims via eight-inch diskette. The format addresses an

industry accepted standard format for billing and reimbursing prescription drug claims for pharmacy users.

c. Magnetic Stripe Standard Format - This standard assists in the magnetic encoding of third-party program plastic industry requirement. NCPDP recommends the use of a standardized encoding format for identification cards that can be read by most, if not all, in-store backcard readers.

d. Member Enrollment Standard and Implementation Guide - This Standard was designed in a segment architecture to allow for variation dictated by the business partners using this information. The format is intended to be easily implemented, and provides flexibility for modifications based on new requirements for changes in technology (i.e., ANSI ASC X12 implementation).

e. Manufacturer Rebates, Utilization, Plan and Formulary Flat File Standard and Implementation Guide - The NCPDP Manufacturer Rebate Utilization, Plan, and Formulary Flat File Standard provides a standardized format for the electronic submission of rebate information from Pharmacy Management Organizations (PMOs) to Pharmaceutical Industry Contracting Organizations (PICOs). The three (3) file formats are intended to be used in an integrated manner, with the utilization file being supported by the plan and formulary files. However, any of the three (3) files may be used independently. The flat file standard layouts provide detailed information on the file design and requirements for each of the three (3) files.

f. Payment Reconciliation (Claims Billing Tape Format) - The model tape format is compatible to and consistent with the standard Universal Claim Form to enable logical progression from a manual claims submissions system to an automated billing process. The form utilizes both data elements and program logic that include: the use of industry accepted data elements; contingency allowance for future enhancements; and compatibility of the format to most existing processing systems.

g. Payment Reconciliation (Payment Tape Format) - The document provides guidance in the alignment of the current payment tape standard and the 835 version 3Ø7Ø guidelines for implementing the ASC X12N 835 Health Care Claim Payment Advice for Pharmacy Claims. The document should be used in conjunction with the ASC X12N Health Care Claim Payment/Advice Implementation Guide Version 2.Ø to ensure a consistent implementation of the standard.

h. Pharmacy ID Card Implementation Guide - The Pharmacy ID Card Implementation Guide is intended to provide guidelines for organizations or entities producing member identification (ID) cards for use in the pharmaceutical drug claim industry and to promote a consistent implementation of the NCPDP adopted ID card standard throughout the industry.

i. Prior Authorization Standard/Implementation Guide - The NCPDP Prior Authorization Transaction Implementation Guide is intended to meet two needs within the pharmaceutical drug claim industry; to provide a practical guideline for software developers throughout the industry as they begin to implement the standard, and to ensure a consistent implementation throughout the industry.

j. SCRIPT Standard/Implementation Guide - The SCIRPT document was developed for the purpose of transmitting prescription information electronically between prescribers and providers. It adheres to EDIFACT syntax requirements and utilizes standard EDIFACT and ASC X12 data tables where possible. Currently, the standard addresses the electronic transmission of new prescriptions, prescription refill requests, prescription fill status notifications, and cancellation notifications. Future enhancements will address other data communication possibilities that may include patient status requests, compliance, lab values, diagnosis, disease management protocols, patient drug therapy profiles, DUR alerts, prescription transfers, formulary recommendations, etc.

k. ORDUR Application Manual (Component for the Telecommunication Standard Version 3 Release 2) - The purpose of this manual is to facilitate the performance of ORDUR as a component of an ECM system because inappropriate drug therapy can cause patient injury leading to the provision of additional health care services resulting in increased total health care expenditures.

l. Professional Pharmacy Services (PPS) Implementation Guide (Component for the Telecommunication Standard Version 3 Release 2) - The document is intended to support the efficient documentation and transmission of information related to professional services provided by pharmacists.

3. Implement standardized forms and procedures (including electronic standards) regarding the submittal of home infusion claims. Adopt as standards, the recommendations being developed by HIPAA in conjunction with the National Home Infusion Association (NHIA)

C. Benefits

1. A unique identifier for healthcare practitioners who write prescriptions coincides with HIPAA's Administrative Simplification proposed standard for an industry-wide unique Provider identification number.

2. NCPDP format is intended to be easily implemented and provides flexibility for modifications based on new requirements for changing technology (i.e., ANSI ASC X12 Implementation).

3. The format will improve and support the flow of member eligibility information in an accurate and timely manner. Successful transfer and maintenance of this eligibility data provides the foundation for cost containment by limiting claim payment liability.

4. NCPDP Standards help assure that this evolution occurs in a manageable way. The NCPDP's standards for ORDUR processing will also help assure that implementation of DUR messages from multiple ECM processors will be administratively uniform from the pharmacist's perspective. This will help pharmacy computer system vendors in developing optimum system support for pharmacist DUR activity. This means that the resulting DUR activity will help the pharmacist identify and prevent improper drug therapy, but will not excessively impact the pharmacist's operational capacity, cost, or efficiency.

5. The standards include the use of industry accepted data elements, contingency allowance for future enhancements and compatibility of the format to most existing processing systems.

6. Eliminates the majority of paper prior authorizations and provides a standardized format for submittal of prior authorizations.

7. Provides a practical guideline for software developers throughout the industry as they begin to implement the standard, and to ensure a consistent implementation throughout the industry.

8. The adoption and use of this standard in the industry will result in several beneficial effects, including (1) improved quality and continuity of care delivered to patients; (2) enhanced accountability of pharmacists and pharmacy Provider organizations to their clients, and (3) the creation of an electronic documentation and billing infrastructure to support the creation of efficient compensation mechanics for the delivery of professional services by pharmacists to their patients who are enrolled in third-party pharmacy service benefit plans.

D. Steps to Implement

1. Schedule planning and strategy meetings with the pharmacy association.

2. Identify current system problems.
3. Compare current claims standards to the NCPDP standards.
4. Strategize with association members and agree upon standards to implement.
5. Modify and approve variances.

Financial / Operational Impact

Implementation of the above referenced policies, procedures and standards may have a significant impact on the financial and operational aspects of the Payers and Providers participating in the TennCare program. These impacts may result from the incurrence of non-recurring costs related to various system and/or software conversions. Consequently, in order to be designated as a standard, a proposed standard should:

- Improve the effectiveness and efficiency of the TennCare program resulting in cost reductions in administrative expenses;
- Meet the needs of Providers and MCOs cost effectively;
- Be consistent with HIPAA standards, as well as private and public sector health data standards;
- Be cost beneficial in terms of development and implementation costs relative to the benefits of using the standard;
- Have timely development, testing, implementation and updating procedures to achieve administrative simplification;
- Be precise and objective;
- Minimize data collection and paperwork burdens;
- Be flexible to adapt easily to changes in the TennCare infrastructure and information technology.

The above referenced criteria are similar to those included in the proposed HIPAA regulations. As previously stated, converting to these standards will result in one-time conversion costs for health care Providers and MCOs. These may be incurred either directly by the Provider / plan or through fees charged by healthcare clearinghouses.

In addition to the cost considerations, temporary disruption in a managed care organization's ability to process health care claims could result. For example, technological limitations of existing systems could affect the complexity of the system conversion process**.** Therefore, the cost-benefit analysis of these recommendations should be considered prior to implementation.